

Non-pharmacological Approaches to Managing Challenging Behaviors in Dementia

Presented by
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Nursing Home Social Work Network
Webinar Series

This webinar series is made possible through the generous support of the **Retirement Research Foundation**



Lori Nisson Waldberg, LCSW



Lori is a Licensed Independent Clinical Social Worker and has spent 20 years specializing in working with adult and senior clients experiencing emotional, cognitive, and behavioral problems. Lori is a well-known speaker who provides training and education to professionals and caregivers on topics relating to memory changes, mental health, movement disorders and behavioral issues. Lori has provided behavioral health and dementia care consulting at hospitals, outpatient programs, and in long-term care providers. She is the Clinical Director of the Dementia Behavioral Neighborhood at Choice Rehab Care. Lori is joining the Banner Sun Health Research Institute team and will be offering individual, family and group therapy and behavior management for individuals and families coping with cognitive and movement disorders. Lori believes strongly in community involvement and is an active participant in the Regional Leadership Council at the Alzheimer's Association and an active member of Area Agency on Aging Advisory Board, serving the greater needs of adults and seniors.

3

Robin P. Bonifas, PhD, MSW



Dr. Robin Bonifas is an Assistant Professor at the Arizona State University School of Social Work. She has over 15 years experience working with elders and their families in both long-term care and inpatient psychiatric settings. Her research focuses on enhancing psychosocial care for persons with chronic illness and disability, especially those with comorbid mental health conditions and those requiring nursing home care, and on evaluating curricular interventions designed to prepare social work students for effective practice with older adults. Her current projects examine resident-to-resident aggression in nursing homes, late-life bullying and other challenges to social relationships in senior care organizations, and the impact of interprofessional education on students' competencies for collaborative healthcare practice. She is a John A. Hartford Faculty Scholar in Geriatric Social Work and earned her doctorate from the University of Washington in Seattle in 2007. She serves on the board of directors for the Association of Gerontology Education in Social Work and is a consulting editor for *Health and Social Work*.

4

Objectives

1. Participants better understand the regulatory guidelines that address challenging behavioral symptoms
2. Participants will be able to identify common behavior problems in persons with dementia
3. Participants will acquire 3 more effective strategies for managing challenging behaviors in dementia
4. Participants will be able to identify 3 creative ways to offer care to residents with dementia

5

Regulatory Guidelines

- Addressing challenging behavioral symptoms first requires the use of non-pharmacological interventions rather than pharmacological interventions.
- Before presenting key non-pharmacological interventions, let's review components of two important F-tags associated with behavioral management...

6

Regulations: Psychotropic Medications

- F-tag 329: Unnecessary Drugs
- F-tag 330: Antipsychotic Drugs



7

Purpose of Regulations Regarding Unnecessary Drugs

- The goals of these regulations and guidelines are to:
 - Stimulate appropriate differential diagnosis of “behavioral symptoms” so the underlying cause of the symptoms is recognized and treated appropriately.
 - Prevent the use of psychopharmacological drugs when the “behavioral symptom” is caused by conditions such as:
 - Environmental stressors
 - Psychosocial stressors
 - Treatable medical conditions

8

F-tag 329: Unnecessary Drugs

- Each resident’s drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:
 - In excessive dose (including duplicated therapy); or
 - For excessive duration; or
 - Without adequate monitoring; or
 - **Without adequate indications for its use**; or
 - In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
 - Any combinations of the reasons above.

9

Consider the phrase:

“Without adequate indications for its use”

If non-pharmacological interventions have not been tried, there is not sufficient evidence that the psychotropic medication is needed to minimize behavioral symptoms.

10

Psychotropic Medications that can be characterized as Unnecessary Drugs

- Types of psychotropic medications to be familiar with:
 - Benzodiazepines
 - Anxiolytics/Sedatives
 - Hypnotics
 - Antipsychotics

11

Benzodiazepines and Other Anxiolytic or Sedative Drugs

- Use is for one of the following indications:
 - Generalized anxiety disorder
 - Delirium, dementia, and amnesic and other cognitive disorders with associated agitated behaviors, which
 - Are quantitatively and objectively documented,
 - **Are persistent and not due to preventable reasons**,
 - Constitute sources of distress or dysfunction to other residents, or
 - Represent a danger to the resident or others.
 - Panic disorder
 - Symptomatic anxiety that occurs in residents’ with another diagnosed psychiatric disorder.

12

Consider the phrase

“Are persistent and not due to preventable reasons”

If non-pharmacological interventions have not been tried, there is not sufficient evidence that the psychotropic medication is needed to minimize behavioral symptoms.

13

F-tag 330: Antipsychotic Drugs

Antipsychotic drugs should not be used if one or more of the following is/are the only indication:

- Wandering
- Poor self care
- Restlessness
- Impaired memory
- Anxiety
- Depression (without psychotic features)
- Insomnia
- Unsociability
- Indifference to surroundings
- Fidgeting
- Nervousness
- Uncooperativeness
- Agitated behaviors which do not represent danger to the resident or others.

14

Non-pharmacological interventions are appropriate aspects of addressing all the challenging behaviors on the previous slide.

Let’s learn more about factors contributing to behavioral symptoms and some specific intervention strategies...

15

Sensitivity

- Dementia affects one’s ability to manage their environment, communicate and behave conventionally
- Behavioral changes are part of the disease process
 - typically not volitional
- They require us to do a better job as care providers anticipating needs while using compassion and empathy

Purpose

- Behavior has a purpose
 - People with dementia are often demonstrating a need
- Ex. A person took all the clothes out of the closet on a daily basis
 - Shows a need to be busy and productive
- Always consider what need the person might be trying to meet with their behavior
 - try to accommodate the need

Triggers

- Behavior is typically triggered by an impetus
- Our role as caretakers is to be detectives
- The goal is to assess what caused the behavior and try to change the pattern
- By utilizing a different approach we can work toward a different outcome

Understanding Behaviors

- 80% of those with dementia will experience some behavioral disturbance
- Most behaviors occur in the moderate stages of Alzheimer's disease and earlier in Lewy Body Dementia and Frontotemporal Dementia
- Often emotional symptoms are seen in early stage
 - Loss, frustration, depression & anxiety
- Often behavioral symptoms worsen as the day progresses

Progression

- As the disease progresses as do behavioral changes
 - As well as physical decline
- Process means that solutions that are effective today may need to be modified or may no longer work at all
- Key to managing difficult behaviors is being creative and flexible in strategies to address the given challenge

Common Types of Behaviors

- Agitation
- Physical Aggression
- Psychosis
- Hypersexual behavior/Disrobing
- "Sundowning"

Common Types of Behaviors

- Wandering
- Rummaging
- Repetitive questioning
- Yelling or calling out
- Sleep disturbances

Understanding Behaviors: The Brain

- Dementia affects areas in the brain that control emotion and behavior.
- The person's ability for insight and judgment are impaired.

Understanding Behaviors: Confusion

- Confusion limits one's ability to understand their surrounding and express themselves conventionally.
- A confused person will often act out due to fear and the inability to express themselves adequately.

Understanding Behaviors: Care

- The person with dementia often requires a great deal of hands-on care.
- This puts the caregiver in a position of being intrusive and limiting privacy.

Understanding Behavior: Physical Pain

- People affected by dementia experience a great deal of physical pain.
- Often pain is expressed through emotional lability and behavior.
- Often pain goes untreated in these people as they have difficulty voicing their pain.

Understanding Behavior: Physical Pain

- Recent research on resident-to-resident aggression (RRA) indicates pain is associated with incidents.
- However, the association is in unexpected direction!
- Greater pain intensity is associated with fewer incidents of RRA, but incidents that do occur are more severe (likely to cause injury).

27

Understanding Behavior: Delirium

- People with dementia are susceptible to infections.
- Often it is difficult to discern what may be delirium and what is an underlying dementia.
- Often infections go untreated in this population.

Understanding Behavior: Delirium

- People with dementia are high risk for adverse medication reactions.
- Acute and rapid changes in mood, cognition, psychosis and behavior are often signs of delirium.
- A medical evaluation is a necessary intervention.

Understanding Behavior: Environment

- An over-stimulating (noisy) environment can cause a spike in behavior.
- A change in environment (a move or travel) can cause an increase in behavior.
- An under-stimulating setting (boredom) can also lead to behavioral disturbance.

Understanding Behavior: Environment

- People with dementia require a calm yet structured setting.
- Structure and daily activity is critical.

Managing Behaviors: Agitation and Wandering

- Look for sensory overload: loud overhead speakers, television and other loud noise can quickly agitate the person.
- Intervene early and often.
 - Look for the early signs of agitation and attend to that person immediately
- Anticipate needs, be aware that person may be too warm or cold.

Managing Behaviors: Agitation and Wandering

- May be an indicator for the need for toileting.
- 2 hour prompting is often effective.
- Wanderers should not be restrained, we need to modify their environment.
- Post stop signs, put a very dark rug or even paint a mural over exit doors to distract the wanderer.

Managing Behaviors: Agitation and Wandering

- Make sure to offer walks to those who care able.
 - This may take more staff or time but will minimize agitation
- Consistency in caregivers will minimize agitation.
- Always introduce yourself
 - Don't expect the person to know your name no matter how long you have known them

Managing Behaviors: Agitation and Wandering

- If agitated folks are not given structured activities particularly early in the day, they will become agitated from boredom.
- Assist people looking for "missing" belongings, never scold.
- Allow persons to carry an old wallet paper money if it makes them feel more comfortable.

Managing Behaviors: Agitation and Wandering

- Consider a behavioral logs to identify patterns of behavior.
 - Behavioral plans are implemented to encourage **staff** to change their approach
- Allow for enough rest, short afternoon naps, allowing some residents to sleep in if that is their pattern.
 - Avoid extensive napping or staying in bed most of the day as this will promote agitation and night-time insomnia

Managing Behaviors: Agitation and Wandering

- Beware of approaching person from behind.
 - Sensory deficits make them easily startled
- Always redirect and distract out of stressful situations.

Managing Behaviors: Verbal and Physical Aggression

- Often most calling out behavior can be most challenging in a hospital or residential setting.
- Often these are WC bound people who cannot ambulate without assistance.
 - If at all possible, assist them in walking short distances
 - exercise reduces agitation

Managing Behaviors: Verbal and Physical Aggression

- If the person cannot ambulate, make sure they are repositioned often
 - place in a recliner chair for comfort.
- The person may be experiencing a separation anxiety and soothed by being placed near a family member or caregiver.

Managing Behaviors: Verbal and Physical Aggression

- Consider hard candy to keep the mouth engaged.
- Often these people have undiagnosed with physical pain
 - consider OTC pain reliever.

Managing Behaviors: Verbal and Physical Aggression

- Consider hand massages with aromatic lotions.
- Try soft music or relaxation tapes of soothing nature tones
 - bird chirping or ocean waves

Managing Behaviors: Verbal and Physical Aggression

- When someone is verbally escalating, often using a respectful, directive tone can be helpful.
- Call person Mrs. or Sir to show respect for their authority.
- Asking someone to relax may be interpreted as condescending.

**Managing Behaviors:
Verbal and Physical Aggression**

- Physical aggression can be difficult to manage in a group setting.
- Utilize a quiet room where the person could be guided to spend time de-escalating.
- If an altercation arises, gently guide peers out of the room without panic or anger.

**Managing Behaviors:
Verbal and Physical Aggression**

- Chronic aggression is often a signal for a behavioral health assessment.
- Additional crisis prevention training in verbal and physical de-escalation techniques is helpful.

**Managing Behaviors:
Verbal and Physical Aggression**

- Recent research reveals numerous good practice approaches nursing home social workers employ to address resident-to-resident aggression.
- Here are some example strategies social workers are using that you may also want to incorporate in your practice...

45

**Managing Behaviors:
Verbal and Physical Aggression**

- Incorporate social work values into overall behavioral management plan
 - Really getting to know residents as people and helping other staff to know them
 - Creating “living” social histories that capture who the person is and what is meaningful to him or her



46

**Managing Behaviors:
Verbal and Physical Aggression**

- Bolster interdisciplinary team effectiveness and communication, insure everyone’s voice is heard.
- Develop policies and procedures that guide reflective practice – critical thinking is built into the process
- Foster relationships with interdisciplinary colleagues, which includes staff closest to the resident

47

**Managing Behaviors:
Hypersexual and Disrobing**

- Redirect persons with dementia away from peers that may trigger sexual behavior.
- If the person is self-stimulating, calmly redirect that person to a private place where they may engage in the behavior.
- Distract attention away from problem situations, but don’t confront the person

Managing Behaviors: Hypersexual and Disrobing

- Be aware of these cues.
- Make sure clothes are comfortable and room temperature is comfortable.
- Consider comfortable clothing that is not easy to remove.
- Consider restrictive clothing, one piece back-zip garments (Buck and Buck).

Managing Behaviors: Hypersexual and Disrobing

- Distract attention away from problems situations.
- Do not confront or scold.
- Often disrobing behavior is related to discomfort or toileting needs.

Managing Behaviors: Psychosis

Paranoia or unrealistic fears are common may benefit from a psychiatric or neurological evaluation.

- Often people refuse meds or food because they are afraid
- Sometimes offering sealed food can make them more comfortable

Managing Behaviors: Psychosis

Delusions (false, fixed beliefs) of other types are also quite common.

- Believing one has to get to work or pick-up children from school.
- Step into that person's reality.
- Listen and do not contradict them.
- Remember sensory deprived are more apt to experience psychosis.
 - Ex. She can't hear well, so she will personalize staff humor as laughing at her

Managing Behaviors: Psychosis

- Make accommodations in the environment to increase comfort.
- Never argue, reminisce about the work instead.
- Respond as if you were an employee, "I will take care of that immediately".

Managing Behaviors: Psychosis

- If the person feels they need to leave, reason that it will take you some time to get a ride arranged.
- Or comment on the severity of weather conditions.
- Then distract with an activity or snack "while they are waiting".
- Behavioral intervention is often enough to soothe or redirect the person.

Managing Behaviors: Psychosis

Hallucinations (hearing or seeing things) are less common and may indicate a need for a psychiatric or neurological evaluation.

- These are sensory experiences
 - Auditory, visual, olfactory, tactile
 - Hearing people on the roof, seeing animals in the room, smelling gases from the vents, feeling bugs on their skin

Managing Behaviors: Psychosis

- Do not argue with the person or try to implement reality.
- If they are seeking a dead spouse, they will either grieve or think you are lying if you remind them.
- Instead reminisce about that person.
 - “How did you two meet? What kind of work did he do? Was it love at first sight?”

Managing Behaviors: Psychosis

- Provide reassurance, “That must be scary” or, “How can I help?”
- Often psychosis is seen in the middle stages of Alzheimer’s, but often occurs in the early stages of Lewy Body Dementia.
- Medication can be useful if the psychosis is distressing or impacting activities of daily living.

Vignette

- Maria
 - 85 y.o. Italian American widowed female
 - Dementia with behavioral disturbance
 - Ambulatory, requires ADL assist, impaired sleep cycle, kidney disease, hypertension, osteoarthritis, advanced foot bunions

Vignette

- Maria
 - 85 y.o. Italian American widowed female
 - Dementia with behavioral disturbance
 - Behavior challenges: impaired sleep cycle
 - Mood lability: rapidly cycling mood
 - Periods of agitation, pacing
 - Speaks a blend of English and Italian

Vignette

- Maria
 - 85 y.o. Italian American widowed female
 - Anger
 - Verbal and gesturing of anger directed at staff/peers
 - Psychosis
 - Delusions: believes some peers/staff are her family members at times (granddaughter Paige)
 - Delusions: people are in her home and she wants them to leave
 - Delusions: thinks a male peer is her husband

Vignette

- Maria
 - What are approaches you might use to manage her behavior?
 - How would you intervene when she is angry with peers?
 - How might you approach her erratic sleep cycle?
 - What behavioral interventions or activities would you try to implement?

The Cardinal Rules

- Always **redirect** and **distract** out of stressful situations.

This webinar series is made possible through the generous support of the **Retirement Research Foundation**



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64

Thank you.

A recording of this webinar is available through the **National Nursing Home Social Work Network** website:

<http://clas.uiowa.edu/socialwork/nursing-home/webinars>

